		FOR OHF USE					

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2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0044362

Facility Name: Resurrection Nursing & Rehabilitation Center

Address: 1001 North Greenwood (Number) Park Ridge (City) 60068 (Zip Code)

County: Cook

Telephone Number: 847-692-5600 **Fax #** 847-692-2305

IDPA ID Number: 23-7061646-004

Date of Initial License for Current Owners: 05-01-80

Type of Ownership:

X	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
X	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code	501-C-3		Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Steve N. Lavenda **Telephone Number:** (847) 236-1111

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 07/01/00 to 06/30/01 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) SEE ACCOUNTANT'S REPORT ATTACHED (Date)
(Print Name and Title) Richard Sgarlata, C.P.A.
(Firm Name & Address) FROST, RUTTENBERG & ROTHBLATT, P.C.
111 Pfingsten Rd., Suite 300, Deerfield, IL 60015
(Telephone) (847)236-1111 Fax # (847)236-1155

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	298	Skilled (SNF)	298	108,770	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	298	TOTALS	298	108,770	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	27,994	51,339	18,961	98,294	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	27,994	51,339	18,961	98,294	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 90.37%

D. How many bed-hold days during this year were paid by Public Aid?
NONE (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
NONE

F. Does the facility maintain a daily midnight census? YES

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [X]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 02/01/80

J. Was the facility purchased or leased after January 1, 1978?
YES [X] Date 02/01/80 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 78 and days of care provided 18,961

Medicare Intermediary Adminastar Federal

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 06/30/01 Fiscal Year: 06/30/01

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Resurrection Nursing & Rehabilitation Cente # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	A. General Services											
1	Dietary	568,362	81,397	22,840	672,599		672,599		672,599			1
2	Food Purchase		639,917		639,917		639,917	(28,295)	611,622			2
3	Housekeeping	377,065	48,711		425,776		425,776		425,776			3
4	Laundry	160,946	71,462		232,408		232,408		232,408			4
5	Heat and Other Utilities			326,715	326,715		326,715		326,715			5
6	Maintenance	105,904	17,586	84,415	207,905		207,905	(1,637)	206,268			6
7	Other (specify):*											7
8	**TOTAL General Services**	1,212,277	859,073	433,970	2,505,320		2,505,320	(29,932)	2,475,388			8
	B. Health Care and Programs											
9	Medical Director			18,876	18,876		18,876		18,876			9
10	Nursing and Medical Records	4,861,413	122,403	392,643	5,376,459		5,376,459	5,058	5,381,517			10
10a	Therapy	54,619	7,045	20,573	82,237		82,237		82,237			10a
11	Activities	107,898	4,900	499	113,297		113,297		113,297			11
12	Social Services	204,695	8,045	350	213,090		213,090		213,090			12
13	Nurse Aide Training											13
14	Program Transportation			347	347		347		347			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	5,228,625	142,393	433,288	5,804,306		5,804,306	5,058	5,809,364			16
	C. General Administration											
17	Administrative	89,967		1,037,803	1,127,770		1,127,770	(1,037,803)	89,967			17
18	Directors Fees											18
19	Professional Services			8,680	8,680		8,680	307,592	316,272			19
20	Dues, Fees, Subscriptions & Promotions			15,994	15,994		15,994	(2,813)	13,181			20
21	Clerical & General Office Expenses	369,297	27,466	45,885	442,648		442,648	413,343	855,991			21
22	Employee Benefits & Payroll Taxes			1,812,448	1,812,448		1,812,448	95,881	1,908,329			22
23	Inservice Training & Education											23
24	Travel and Seminar			12,460	12,460		12,460	(1,492)	10,968			24
25	Other Admin. Staff Transportation			937	937		937	(416)	521			25
26	Insurance-Prop.Liab.Malpractice			236,522	236,522		236,522		236,522			26
27	Other (specify):*											27
28	**TOTAL General Administration**	459,264	27,466	3,170,729	3,657,459		3,657,459	(225,708)	3,431,751			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	6,900,166	1,028,932	4,037,987	11,967,085		11,967,085	(250,582)	11,716,503			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center #0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			620,549	620,549		620,549	19,659	640,208			30
31	Amortization of Pre-Op. & Org.											31
32	Interest											32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			25,538	25,538		25,538		25,538			35
36	Other (specify):*											36
37	**TOTAL Ownership**			646,087	646,087		646,087	19,659	665,746			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers	651,361	1,521,061	49,808	2,222,230		2,222,230	(1,386,864)	835,366			39
40	Barber and Beauty Shops			29,149	29,149		29,149	(29,149)				40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			163,155	163,155		163,155		163,155			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**	651,361	1,521,061	242,112	2,414,534		2,414,534	(1,416,013)	998,521			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	7,551,527	2,549,993	4,926,186	15,027,706		15,027,706	(1,646,936)	13,380,770			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	733	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(1,813)	20		24
25	Fund Raising, Advertising and Promotional				25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(67,932)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (69,012)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	(1,577,924)		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ (1,577,924)		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ (1,646,936)		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Resurrection Nursing & Rehabilitation Center

ID# 0044362

Report Period Beginning: 07/01/00

Ending: 06/30/01

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2	NON-CARE RELATED DEPRECIATION	(1,145)	30	2
3	CAPITALIZED REPAIRS & MAINT. 2000	(5,678)	6	3
4	CAFETERIA - EMPLOYEES	(18,363)	2	4
5	CAFETERIA - VISITORS	(2,987)	2	5
6	OUTSIDE TRIPS	(47)	21	6
7	MISC.	(710)	21	7
8	FOOD REBATES	(6,945)	2	8
9	BARBER & BEAUTY INC. (UP TO EXP.)	(29,149)	40	9
10	CIVIL MONEY PENALTY	(1,000)	20	10
11	OUT OF STATE TRANSPORTATION	(416)	25	11
12	OUT OF STATE SEMINAR	(1,492)	24	12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(67,932)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	(28,295)	0	0	0	0	0	0	0	0	0	0	(28,295)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(5,678)	4,041	0	0	0	0	0	0	0	0	0	(1,637)	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	(33,973)	4,041	0	0	0	0	0	0	0	0	0	(29,932)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	5,058	0	0	0	0	0	0	0	0	0	5,058	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	5,058	0	0	0	0	0	0	0	0	0	5,058	16
	C. General Administration													
17	Administrative	0	(1,037,803)	0	0	0	0	0	0	0	0	0	(1,037,803)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	307,592	0	0	0	0	0	0	0	0	0	307,592	19
20	Fees, Subscriptions & Promotions	(2,813)	0	0	0	0	0	0	0	0	0	0	(2,813)	20
21	Clerical & General Office Expenses	(757)	414,100	0	0	0	0	0	0	0	0	0	413,343	21
22	Employee Benefits & Payroll Taxes	0	95,881	0	0	0	0	0	0	0	0	0	95,881	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(1,492)	0	0	0	0	0	0	0	0	0	0	(1,492)	24
25	Other Admin. Staff Transportation	(416)	0	0	0	0	0	0	0	0	0	0	(416)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(5,478)	(220,230)	0	0	0	0	0	0	0	0	0	(225,708)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(39,451)	(211,131)	0	0	0	0	0	0	0	0	0	(250,582)	29

STATE OF ILLINOIS **Summary B**

Facility Name & ID Number **Resurrection Nursing & Rehabilitation Center** **#** **0044362** **Report Period Beginning:** **07/01/00** **Ending:** **06/30/01**

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	(412)	20,071	0	0	0	0	0	0	0	0	0	19,659	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	(412)	20,071	0	0	0	0	0	0	0	0	0	19,659	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	(1,386,864)	0	0	0	0	0	0	0	0	0	(1,386,864)	39
40	Barber and Beauty Shops	(29,149)	0	0	0	0	0	0	0	0	0	0	(29,149)	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	(29,149)	(1,386,864)	0	0	0	0	0	0	0	0	0	(1,416,013)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(69,012)	(1,577,924)	0	0	0	0	0	0	0	0	0	(1,646,936)	45

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Resurrection Health Care	100	See Attached		See Attached		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V		21	Salary	$	Resurrection Health Care/Resurrection Medical Center		$ 337,205	$ 337,205	1
2	V		22	Employee Benefits				95,881	95,881	2
3	V		19	Data Processing				262,776	262,776	3
4	V		19	Purchasing				44,816	44,816	4
5	V		6	Operation of Plant				4,041	4,041	5
6	V		10	Nursing Administration				5,058	5,058	6
7	V		21	A&G				76,895	76,895	7
8	V		30	Capital Costs				20,071	20,071	8
9	V									9
10	V		39	Interco. Pharmacy Charges	1,386,864				(1,386,864)	10
11	V		17	Interco. Contracted Services	1,037,803				(1,037,803)	11
12	V									12
13	V									13
14	Total				$ 2,424,667			$ 846,743	$ * (1,577,924)	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Resurrection Nursing & Rehabilitation Cent # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	N/A								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Resurrection HC/Medical Center
Street Address: 7435 W. Talcott
City / State / Zip Code: Chicago, IL 60631
Phone Number: (773) 774-8000
Fax Number: (773) 594-7488

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	21	Salary				$	$		$ 337,205	1
2	22	Employee benefits							95,881	2
3	19	Data Processing							262,776	3
4	19	Purchasing							44,816	4
5	6	Operation of Plant							4,041	5
6	10	Nursing Administration							5,058	6
7	21	A&G							76,895	7
8	30	Capital Costs							20,071	8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$ 846,743	25

Facility Name & ID Number Resurrection Nursing & Rehabilitation Cente # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	N/A						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6	N/A											6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10	N/A											10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center **#** 0044362 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2000 report.	*Important*, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$ N/A	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)		$ N/A	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$ N/A	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$ N/A	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
	1996	8
	1997	9
	1998	10
	1999	11
	2000	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2000	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Resurrection Nursing & Rehabilitation Center COUNTY Cook

FACILITY IDPH LICENSE NUMBER 0044362

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 99,460 B. General Construction Type: Exterior BRICK & BLOCK Frame STEEL Number of Stories 3 PLUS GROUND

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [X] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	FACILITY AND	126,500	1983	$ 580,293	1
2	PARKING AREA				2
3	TOTALS	126,500		$ 580,293	3

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	298			1976	$ 6,276,546	$ 209,278	30	$ 209,278	$	$ 3,766,798	4
5				1976	1,733,006	4,130	VARIOUS	4,130		1,722,720	5
6											6
7											7
8											8
	Improvement Type**										
9	VARIOUS			1981	3,549		VARIOUS			3,549	9
10	VARIOUS			1983	35,281		VARIOUS			35,281	10
11	VARIOUS			1985	3,892	195	VARIOUS	195		3,315	11
12	VARIOUS			1986	14,629	731	VARIOUS	731		11,696	12
13	VARIOUS			1987	41,215	2,061	VARIOUS	2,061		30,915	13
14	VARIOUS			1988	40,512	2,026	VARIOUS	2,026		28,364	14
15	VARIOUS			1989	190,627	9,531	VARIOUS	9,531		123,903	15
16	VARIOUS			1990	171,816	8,591	VARIOUS	8,591		103,092	16
17	VARIOUS			1991	60,020	3,001	VARIOUS	3,001		33,011	17
18	VARIOUS			1992	107,965	5,398	VARIOUS	5,398		53,980	18
19	VARIOUS			1993	105,120	5,256	VARIOUS	5,256		47,304	19
20	VARIOUS			1994	259,632	12,982	VARIOUS	12,982		103,856	20
21	VARIOUS			1995	630,342	31,517	VARIOUS	31,517		220,619	21
22	PARKING LOT EXPANSION			1996	13,265	1,659	8	1,659		9,121	22
23	RENOVATION OF REHAB UNIT			1996	3,250	191	17	191		1,051	23
24	WINDOW TREATMENTS			1996	3,500	350	10	350		1,925	24
25	RENOVATION OF EMPLOYEE DINING AREA			1996	1,277	256	5	256		1,408	25
26	NEW DOOR FOR FRONT LOBBY			1996	976	65	15	65		358	26
27	RENOVATION OF SHOWER ROOM			1996	8,148	543	15	543		2,987	27
28	RENOVATION OF DINING AREAS			1996	59,265	3,520	17	3,520		19,360	28
29											29
30											30
31											31
32											32
33											33
34											34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	HOT WATER HEATER	1996	$ 14,900	$ 1,490	10	$ 1,490	$	$ 8,195	37
38	NEW DOOR, GROUND FLOOR	1996	754	50	15	50		225	38
39	PARKING LOT ADDITION	1997	108,669	7,304	15	7,304		32,868	39
40	LANDSCAPING	1997	36,111	3,611	10	3,611		16,250	40
41	ELEVATOR RENOVATIONS	1997	37,893	1,895	20	1,895		8,528	41
42	WIRING FOR COMPUTER APPLICATIONS	1997	12,881	654	20	654		2,943	42
43	OCCUPATIONAL THERAPY RENOVATIONS	1997	240,950	14,172	17	14,172		63,775	43
44	DINING ROOM RENOVATIONS	1997	95,391	5,748	17	5,748		25,866	44
45	ROOFTOP HVAC UNITS, INCLUDING INSTALL	1997	220,226	14,110	15	14,110		63,495	45
46	CARPETING	1997	62,031	12,406	5	12,406		55,827	46
47	HAND RAILS	1997	24,153	1,646	15	1,646		7,407	47
48	NEW FLOOR TILES, INCLUDING INSTALL	1997	103,959	10,396	10	10,396		46,783	48
49	NEW CEILING TILES, INCLUDING INSTALL	1997	43,340	4,334	10	4,334		19,503	49
50	DESIGNS, DRAW, ETC FOR VARIOUS PROJECTS	1997	51,893	5,189	10	5,189		23,351	50
51	PATCH PAINT, ETC.	1997	47,600	9,520	5	9,520		42,840	51
52	DRAPERIES	1997	27,180	5,436	5	5,436		24,462	52
53	REPLACE LIGHTING FIXTURES	1997	5,887	588	10	588		2,646	53
54	RESTORE LAUNDRY ROOM TRENCH	1997	8,559	570	15	570		1,995	54
55	FIRE DAMPERS, INCLUDING INSTALL	1997	3,520	234	15	234		819	55
56	DESIGN SERVICES, FOOD SERVICE REMODEL	1998	2,607	260	10	260		910	56
57	ENTRANCEWAY CARPETING	1998	1,295	260	5	260		910	57
58	FIRST FLOOR REMODELING	1998	6,732	674	10	674		2,359	58
59	NURSE CALL LIGHT SYSTEM	1998	37,299	2,486	15	2,486		8,701	59
60	WORK STATIONS - SPEECH THERAPY	1998	6,405	428	15	428		1,498	60
61	AIR TEST & BALANCE - HVAC SYSTEM	1998	6,200	620	10	620		2,170	61
62	BY-PASS VALVE FOR BOILER	1998	2,963	296	10	296		1,036	62
63	HEATING COILS FOR AIR HANDLER	1998	5,300	530	10	530		1,855	63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 10,978,531	$ 406,188		$ 406,188	$	$ 6,791,830	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 10,978,531	$ 406,188		$ 406,188	$	$ 6,791,830	1
2	ELECTRICAL WORK 7/99	1999	2,005	134	15	134		268	2
3	DINING ROOM SHADES 12/99	1999	1,600	108	15	108		216	3
4	JOINT COMPOUND 12/99	1999	3,657	244	15	244		488	4
5	PRIMER, TINT, PAINT 12/99	1999	351	24	15	24		48	5
6	WALLPAPER 12/99	1999	428	30	15	30		60	6
7	PATIENT PHONES 12/99	1999	744	50	15	50		100	7
8	MESSAGE WAITING LINE CARDS & TRUNK CARDS 12/99	1999	4,337	288	15	288		576	8
9	WIRING 12/99	1999	1,184	80	15	80		160	9
10	WALLPAPER 12/99	1999	398	26	15	26		52	10
11	FLOORING - 3RD FLOOR - B WING 12/99	1999	16,835	1,122	15	1,122		2,244	11
12	CUBICLE CURTAINS 12/99	1999	4,221	280	15	280		560	12
13	PLANNING & PERMIT DRAWINGS 12/99	1999	630	42	15	42		84	13
14	DESIGN ON INTERNET 12/99	1999	1,258	84	15	84		168	14
15	WALLPAPER 12/99	1999	4,393	292	15	292		584	15
16	WALLPAPER SUPPLIES 12/99	1999	85	6	15	6		12	16
17	FLOORING - TV ROOM 12/99	1999	1,795	120	15	120		240	17
18	ALTERATIONS - 2ND FLOOR 12/99	1999	48,302	3,220	15	3,220		6,440	18
19	DESIGN DISHWASHING AREA 12/99	1999	4,856	324	15	324		648	19
20	SINKS, DISHTABLES, DISHMACHINES, HEATERS 12/99	1999	43,113	2,874	15	2,874		5,748	20
21	DTI/PRI COMMUNICATION PACKAGE 12/99	1999	1,391	92	15	92		184	21
22	FLOORING - 3RD FLOOR - A WING 12/99	1999	18,525	1,234	15	1,234		2,468	22
23	FLOORING - 3RD FLOOR - C WING 12/99	1999	18,525	1,234	15	1,234		2,468	23
24	REMOVAL OF FLOOR TILE 12/99	1999	2,833	190	15	190		380	24
25	DOOR OPERATING SYSTEM 12/99	1999	2,758	184	15	184		368	25
26	FLOORING - 3RD FLOOR - D WING 12/99	1999	18,525	1,236	15	1,236		2,472	26
27	LIGHT FIXTURES 12/99	1999	7,300	488	15	488		976	27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,188,580	$ 420,194		$ 420,194	$	$ 6,819,842	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 11,188,580	$ 420,194		$ 420,194	$	$ 6,819,842	1
2	LIGHT FIXTURES 12/99	1999	1,804	120	15	120		240	2
3	FIRE DAMPERS 12/99	1999	7,040	468	15	468		936	3
4	REPAIR OF STEAM LEAK 12/99	1999	1,598	108	15	108		216	4
5	HAND SINKS, DISHTABLES, DISHMACHINES 12/99	1999	3,047	204	15	204		606	5
6	LANDSCAPING 7/99 R&M	1999	1,948		10	195	195	390	6
7	REPLACE RELIEF VALVE WATER TANK 11/99 R&M	1999	2,534		10	253	253	506	7
8	CODE ALERT SYSTEM WITH INSTALLATION	2000	8,682	435	20	435		1,303	8
9	HOT WATER HEATER	2000	28,907	964	20	964		3,856	9
10	POWER SMOKE DAMPER	2001	1,850	93	20	93		93	10
11	ELECTRICAL-REWIRING	2001	27,267	1,364	20	1,364		1,364	11
12	NEW PVI FOR BOILER	2001	16,985	850	20	850		850	12
13	GAS VENT LINE FOR BOILER	2001	1,374	69	20	69		69	13
14	REPLACE COMPRESSOR FOR FREEZER	2001	1,061	53	20	53		53	14
15	INSTALL BACK FLOW DEVICE FOR ARJO TUB	2001	985	50	20	50		50	15
16	BOILER SYSTEM REPAIR R&M	2001	886		20	45	45	45	16
17	CODE ALERT SYSTEM WITH INSTALLATION	2001	3,000	150	20	150		150	17
18	CODE ALERT BANDS	2001	1,263	64	20	64		64	18
19	LANDSCAPE UPGRADE	2001	3,525	177	20	177		177	19
20	WALLPAPERING	2001	930	47	20	47		47	20
21	SHOWER BASES REPAIR	2001	16,283	815	20	815		815	21
22	TUBES IN CHILLER R&M	2001	2,681		20	134	134	134	22
23	REPLACE DEFROST CLOCK IN COOLER R&M	2001	1,532		20	77	77	77	23
24	ALARM SYSTEM R&M	2001	579		20	29	29	29	24
25									25
26									26
27									27
28	ALLOC RESURRECTION HEALTH CARE/MEDICAL CTR			20,071		20,071			28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 11,324,341	$ 446,296		$ 447,029	$ 733	$ 6,831,912	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 2,121,077	$ 186,910	$ 186,910	$		$ 1,717,870	71
72	Current Year Purchases	29,482	2,948	2,948			2,948	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 2,150,559	$ 189,858	$ 189,858	$		$ 1,720,818	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	FACILITY	FORD TRUCK	1999	$ 26,878	$ 1,029	$ 1,029	$		$ 2,058	76
77		BUICK CENTURY	1997	18,343	2,292	2,292			18,343	77
78										78
79										79
80	TOTALS			$ 45,221	$ 3,321	$ 3,321	$		$ 20,401	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 14,100,414	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 639,475	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 640,208	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 733	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 8,573,131	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	CHAPEL - VARIOUS	$ 18,534	$ 927	$ 18,076	86
87	SINKS FOR BEAUTY SHOP	4,360	218	218	87
88					88
89					89
90					90
91	TOTALS	$ 22,894	$ 1,145	$ 18,294	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
   If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
   This amount was calculated by dividing the total amount to be amortized
   by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
    Beginning ____
    Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2002	$
13.	/2003	$
14.	/2004	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO
16. Rental Amount for movable equipment: $ 25,538 Description: PITNEY BOWES -COPIERS $12,281 + FOOD SERVICE SYST. $13,257.
    (Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [X] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist	39-1	hrs	$ 193,452		$ 3,083	$		$ 196,535	1
2	Licensed Speech and Language Development Therapist	39-1	hrs	43,315					43,315	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	39-1	hrs	414,594					414,594	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39-2	# of prescrpts				1,386,864		1,386,864	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					46,725	134,197		180,922	13
14	TOTAL			$ 651,361		$ 49,808	$ 1,521,061		$ 2,222,230	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/01 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 9,158	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	2,109,421		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	5,785		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	8,812,960		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 10,937,324	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	580,293		13
14	Buildings, at Historical Cost	10,097,799		14
15	Leasehold Improvements, at Historical Cost	254,587		15
16	Equipment, at Historical Cost	4,403,588		16
17	Accumulated Depreciation (book methods)	(8,814,447)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): See suppl. Schedule	22,123,286		23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 28,645,106	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 39,582,430	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 349,336	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable			30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	See supplemental Schedule	7,572,993		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 7,922,329	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 7,922,329	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 31,660,101	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 39,582,430	$	48

***(See instructions.)**

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 30,812,566	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 30,812,566	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	847,535	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 847,535	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 31,660,101	24 *

*** This must agree with page 17, line 47.**

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 14,353,492	1
2	Discounts and Allowances for all Levels	(3,810,685)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 10,542,807	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	2,504,071	6
7	Oxygen	86,435	7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 2,590,506	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	36,090	13
14	Non-Patient Meals	21,350	14
15	Telephone, Television and Radio		15
16	Rental of Facility Space		16
17	Sale of Drugs	1,609,457	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	844,657	21
22	Laundry	26,456	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 2,538,010	23
	D. Non-Operating Revenue		
24	Contributions	119	24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 119	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See supplemental schedule	203,799	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 203,799	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 15,875,241	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	2,505,320	31
32	Health Care	5,804,306	32
33	General Administration	3,657,459	33
	B. Capital Expense		
34	Ownership	646,087	34
	C. Ancillary Expense		
35	Special Cost Centers	2,251,379	35
36	Provider Participation Fee	163,155	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 15,027,706	40
41	**Income before Income Taxes (line 30 minus line 40)****	847,535	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 847,535	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,940	2,199	$ 66,363	$ 30.18	1
2	Assistant Director of Nursing	1,776	2,157	63,182	29.29	2
3	Registered Nurses	81,822	90,402	2,168,883	23.99	3
4	Licensed Practical Nurses	14,257	16,222	256,272	15.80	4
5	Nurse Aides & Orderlies	194,340	221,137	2,270,745	10.27	5
6	Nurse Aide Trainees					6
7	Licensed Therapist	22,022	24,914	651,361	26.14	7
8	Rehab/Therapy Aides	2,945	3,937	54,406	13.82	8
9	Activity Director	1,853	2,080	41,798	20.10	9
10	Activity Assistants	6,841	7,780	66,100	8.50	10
11	Social Service Workers	9,821	11,466	204,695	17.85	11
12	Dietician	2,992	3,402	49,396	14.52	12
13	Food Service Supervisor	2,079	2,777	54,147	19.50	13
14	Head Cook	2,043	2,198	33,931	15.44	14
15	Cook Helpers/Assistants	8,202	8,906	90,125	10.12	15
16	Dishwashers	35,287	38,989	340,763	8.74	16
17	Maintenance Workers	5,608	6,680	105,904	15.85	17
18	Housekeepers	34,712	38,933	377,065	9.68	18
19	Laundry	17,222	19,821	160,946	8.12	19
20	Administrator	1,840	2,080	89,967	43.25	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	25,332	26,655	369,297	13.85	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,202	1,471	36,181	24.60	31
32	Other Health Care(specify)					32
33	Other(specify)	0	0	0		33
34	TOTAL (lines 1 - 33)	474,136	534,206	$ 7,551,527 *	$ 14.14	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	846	$ 22,840	1-3	35
36	Medical Director	CONTRACT	18,876	9-3	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	143	6,285	10A-3	40
41	Occupational Therapy Consultant	421	14,288	10A-3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	18	499	11-3	44
45	Social Service Consultant	14	350	12-3	45
46	Other(specify)				46
47	URC	CONTRACT	3,600	10-3	47
48	Medical Record-Transcription Fees	Flat Fee	3,636	10-3	48
49	TOTAL (lines 35 - 48)	1,442	$ 70,374		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	3,493	$ 159,323	10-3	50
51	Licensed Practical Nurses	1,290	42,214	10-3	51
52	Nurse Aides	8,921	183,870	10-3	52
53	TOTAL (lines 50 - 52)	13,704	$ 385,407		53

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
NORMA WILSON	ADMINISTRATOR	0	$ 67,473
7.1.2000-3.3. 2001			
NICKI CURTH	ADMINISTRATOR	0	22,494
4.1.2001-6.30.2001			
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 89,967

B. Administrative - Other

Description	Amount
MANAGEMENT FEES - RESURRECTION HEALTH CARE	$ 1,037,803
TOTAL (agree to Schedule V, line 17, col. 3)	$ 1,037,803
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Seyfarth, Shaw, Fairweather	Legal	$ 7,479
McCorkle Court Reporter	Guardianship Services	1,201
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 8,680

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 123,715
Unemployment Compensation Insurance	14,242
FICA Taxes	566,434
Employee Health Insurance	941,287
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Group Life Insurance	11,324
Group Dental Life Insurance	35,929
Group Disability Insurance	39,105
Retirement Plan	53,579
Employee Benefits	2,538
See Schedule Attached	120,176
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,908,329

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed)	
Dues & Subscriptions	5,429
Life Service Network	6,187
Advertising & Promotion	1,813
License	1,565
Less: Public Relations Expense	(1,813)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 13,181

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	10,968
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,968

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center # 0044362 Report Period Beginning: 07/01/00 Ending: 06/30/01

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1	N/A		$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Resurrection Nursing & Rehabilitation Center **#** 0044362 **Report Period Beginning:** 07/01/00 **Ending:** 06/30/01

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **NO**

(2) Are there any dues to nursing home associations included on the cost report? **YES**
If YES, give association name and amount. **LSN $6,187**

(3) Did the nursing home make political contributions or payments to a political action organization? **NO** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **NO** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **YES**
What was the average life used for new equipment added during this period? **10 YRS**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **17,114** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **YES** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **NO**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **163,155**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **NO** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **YES**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **NO** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? **YES** Indicate the amount. $ **21,350**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **NO**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **NO** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients? **N/A**
d. Have vehicle usage logs been maintained? **N/A**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **YES**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**
g. Does the facility transport residents to and from day training? NO
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **YES**
Firm Name: **KPMG PEAT MARWICK** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? **NO** If no, please explain. **NOT AVAILABLE**

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **YES**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **YES**
Attach invoices and a summary of services for all architect and appraisal fees.